

CCHD FAILED SCREEN REPORTING FORM

Utilize this form if the CCHD pulse oximetry screen was failed.

Newborn Demographic Information:

First Name: _____ Last Name: _____

Birth Last Name: _____

DOB (mm/dd/yyyy): _____ Time of birth: _____

Sex: Male Female Indeterminate (Circle One)

Gestational age at birth (weeks): _____ Birth weight (grams): _____

Medical Record Number: _____

Mother Demographic Information:

First Name: _____ Last Name: _____

DOB (mm/dd/yyyy): _____

Address: _____

City: _____ State: _____ Zip: _____

Failed Screening Information:

Date of initial pulse ox screening for CCHD: _____ Military Time: _____

Was a prenatal ultrasound performed? (Circle one) Yes No Unsure

Screening Information	First Pulse Ox Screen Saturation Results	Second Pulse Ox Screen (if indicated) Saturation Results	Third Pulse Ox Screen (if indicated) Saturation Results
Right hand	%	%	%
Foot	%	%	%
Age (in hours)			

Was an echocardiogram performed? (Circle one) Yes No Unsure

If yes - date: _____ Facility Name: _____

Was the patient transferred? (Circle one) Yes No

If yes - Where? (Facility name): _____ Date of transfer: _____

Comment sections on back



Reason for failed screen. What is the final diagnosis that explains the failed pulse oximetry screening?

Cardiac Defects (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Aortic Arch Atresia | <input type="checkbox"/> Pulmonary Stenosis |
| <input type="checkbox"/> Aortic Arch Hypoplasia | <input type="checkbox"/> Single Ventricle |
| <input type="checkbox"/> Coarctation of the Aorta | <input type="checkbox"/> Tetralogy of Fallot |
| <input type="checkbox"/> Double-outlet Right Ventricle | <input type="checkbox"/> Total Anomalous Pulmonary Venous Return |
| <input type="checkbox"/> Ebstein Anomaly | <input type="checkbox"/> Transposition of the Great Arteries |
| <input type="checkbox"/> Hypoplastic Left Heart Syndrome | <input type="checkbox"/> Tricuspid Atresia |
| <input type="checkbox"/> Interrupted Aortic Arch | <input type="checkbox"/> Truncus Arteriosus |
| <input type="checkbox"/> Pulmonary Atresia, intact septum | <input type="checkbox"/> Ventricular Septal Defect |

Other Cardiac Defect(s) – Describe: _____

Non-Cardiac – Explanation: _____

Normal evaluation after failed screen – Explanation: _____

☐ Pending diagnosis – Explain:

Person completing form: _____

Print Name

Title: _____ **Date Completed:** _____

Facility Name: _____

Phone Number: _____

